

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

Volume 3 • Number 5

June 2003

ANNOUNCING IMPORTANT CHANGES IN DISEASE REPORTING: Hospitalized varicella cases now reportable

Hospitalized varicella (chickenpox) cases must now be reported to Public Health within 7 days of identification.

Effective immediately, the California Department of Health Services instituted an important addition to the list of reportable diseases as mandated by the California Code of Regulations (CCR) Title 17, Section 2500 – hospitalized varicella (chickenpox) cases must now be reported to Public Health within 7 days of identification. This is not the first major change in the reporting of varicella; varicella deaths became nationally notifiable in 1999, and in November 2001, the California disease reporting regulations were amended to include immediate reporting of varicella deaths as means

of improving the state's bioterrorism preparedness. Hospitalized varicella cases may be reported using a standard Confidential Morbidity Report (CMR) form available from the county Department of Health Services website (www.lapublichealth.org/acd/reports/Reporting%20Forms/CMR.pdf) and called or faxed to the Morbidity Unit (888-397-3993 phone, 888-397-3778 facsimile).

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Los Angeles County SARS Update: Continued caution and active screening still necessary

Since the first Los Angeles County SARS case was reported in mid-March, Acute Communicable Disease Control has identified on average little more than one new SARS case per week. As of June 15, the cumulative total in the county was 17 SARS cases; 6 probable cases (based on positive chest x-ray) and 11 suspect cases. Of the 17 cases, 3 suspect cases are non-residents who have returned to their country of residence upon receiving clearance for travel. To date, convalescent blood results have been received for 7 cases (5 probable and 2 suspect cases) and all are negative for coronavirus antibodies. There are no reports of associated illness among any local healthcare workers and no evidence of community transmission. In addition, there have been no SARS deaths nationwide. While the incidence of SARS abroad appears to be leveling off, the medical community should remain cautious and alert for potential cases and continue to imple-

ment appropriate infection control practices as needed. SARS information as well as current summaries of Los Angeles cases is available at: www.lapublichealth.org/acd/SARS.htm.

Revised SARS case definition (6-14-03)

As the incidence of SARS cases wanes in areas outside the U.S., the CDC continues to modify the exposure component of the definition for SARS cases. It is important to note that the case definition does not necessarily correspond to areas designated as having health alerts and/or travel advisories. Current information and listings of SARS travel advisories are available at: www.cdc.gov/ncidod/sars/travel.htm. On June 14, the CDC removed Singapore from the epidemiologic criteria for identifying SARS cases. Since Hanoi was removed in late May, just four areas remain on the list

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THE PUBLIC'S HEALTH

is published by:



COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health

313 North Figueroa Street, Room 212
Los Angeles, California 90012

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Sudden Infant Death Syndrome: Patient education proves beneficial

When the state mandated provision of Sudden Infant Death Syndrome (SIDS) risk reduction information for parents and guardians of newborns by delivery facilities and midwives in 1998, it did so in support of the Back To Sleep Campaign, which had proven effective in reducing SIDS rates. The initial recommendation for supine infant sleep positioning was made by the American Academy of Pediatrics in 1992 because it had been shown to cut the SIDS rates significantly. Los Angeles County SIDS deaths have dropped from 69 in 1998 to 9 in 2002.

Labor and delivery are hard work. Fatigued mothers are not as able to absorb patient education during the postpartum and discharge period as they are during third trimester prenatal care when anticipation is at its highest. SIDS safety should be taught then to assure compliance with the SIDS risk reduction recommendations. This could be as common to the pregnant patient education protocol as car seat safety is and not be seen as casting a cloud of anxiety over the pregnancy. In keeping with this, physicians providing pediatric care would do well to reinforce SIDS safety instruction to parents and guardians.

Another area of concern is the increasing number of infant deaths associated with co-sleeping or bed sharing. An autopsy cannot differentiate between accidental smothering and SIDS, so some probable SIDS deaths are diagnosed as "undetermined." Sharing a bed with an intoxicated adult or someone who is very heavy or extremely fatigued is a risk for accidental suffocation. Some cultures traditionally co-sleep, but softer American beds create pockets and slopes that the firmer sleeping surfaces used in other countries do not. Also, some families take the term "crib death" literally as the crib being the cause, so they seek to prevent that by sharing the bed.

The risk of SIDS is also increased by sharing a bed with a smoker even if the infant is not directly exposed to second-hand tobacco smoke. Nicotinic inhibition of sleep arousal has become the leading factor contributing to SIDS events now that prone sleeping has been reduced.

For more information, please contact Grant Neie, RN, PHN, SIDS Program Coordinator at (213) 639-6440 or visit <http://lapublichealth.org/mch/sids/sids.htm> 

SARS: (from page 1)

for travel criteria for SARS case identification: China; Hong Kong; Toronto, Canada; and, Taiwan. Other aspects related to case identification such as required symptoms and date of onset are unchanged.

Exclusion of SARS cases due to alternative diagnosis

Another very important factor in the process of determining a SARS case is the lack of an alternative diagnosis. Many other illnesses have similar presentations as SARS, influenza in particular. If an alternative diagnosis can fully explain the illness, the individual can be excluded as a SARS case. This highlights the importance of clinicians improving their methods for viral testing. A summary of influenza testing methods is available through the CDC at: www.cdc.gov/ncidod/diseases/flu/flu_dx_table.htm.

SARS transmission

The primary method of SARS transmission is close person-to-person contact. Potential transmission also includes touching objects that are contaminated with infectious droplets and then touching your eye(s), nose, or mouth. This can happen when someone who is sick with SARS coughs or sneezes droplets onto themselves, other people, or nearby surfaces. In addition, only individuals with symptoms are believed to spread the disease.

The CDC does **not** advise quarantine for persons arriving from areas with SARS. These individuals should self-monitor for fever and respiratory symptoms for 10 days and contact their physician as soon as possible should illness occur. These instructions and descriptions of SARS symptoms are provided to all airline passengers

SARS definition for case identification (as of 6-14-03)

- Fever ($\geq 38^{\circ}$ C or 100.4° F);
- AND respiratory illness (e.g., cough, shortness of breath, abnormal chest x-ray);
- AND either of the following:
 - History of travel (including including transit in an airport) within 10 days of onset of symptoms to any of the following areas: mainland China; Hong Kong, Toronto, Canada; Taiwan
 - OR
 - Close contact with persons with respiratory illness having the above travel history. Close contact includes caring for, living with, or having had direct contact with respiratory secretions and bodily fluids of a person with suspected SARS.

It is important to note that this definition is intentionally nonspecific and undoubtedly captures many other respiratory illnesses.

arriving from SARS areas. Persons in the U.S. who have recently traveled from SARS areas need not be excluded from public gatherings including academic pursuits, business meetings or other events. In addition, since the average incubation period from two published studies is 5-7 days (range 1-10 days), there is no need to extend the duration of symptom monitoring or quarantine of cases beyond 10 days. While SARS information is advancing almost daily, the limited evidence of transmission beyond droplet contact further supports the CDC's guidelines for infection control and quarantine of cases. Documentation detailing these recommendations for schools or workplaces drafting policies for returning travelers is available at: www.lapublichealth.org/acd/SARS.htm ☞

**Any possible case of SARS should be reported immediately to Acute Communicable Disease Control
213-240-7941 (7:30am - 5:30pm) • 213-974-1234 (after hours, emergency operator)**

TABLE 1: SARS Cases Total* (6-6-03)

LOCATION	SUSPECT CASES	PROBABLE CASES	TOTAL CASES
L.A. County	11	6	17
California	52	21	73
New York	35	9	44
Washington	27	2	29
United States	311	68	379

* All totals except L.A. County from CDC at: www.cdc.gov/od/oc/media/sars.htm

Disease Reporting (from page 1)

This change in reporting is critical to gauge the effectiveness of varicella vaccination and to identify gaps in coverage. Data from CDC funded active surveillance systems in three sites (including Antelope Valley in Los Angeles County) indicate that the epidemiology of varicella is changing dramatically. The Antelope Valley data show an 86% reduction in the number of varicella cases and a marked decline in varicella complications and hospitalizations. Using rates derived from the Antelope Valley project, it is estimated that approximately 97,000 cases currently occur each year in California and that approximately 230 of these cases are hospitalized each year. Recently, the CDC recommended that varicella be included in the National Notifiable Diseases Surveillance System (NEDSS) and that case-based surveillance be implemented by 2005. However, there are still too many cases occurring in California to make case-based surveillance for varicella feasible. After consultation with the California Conference of Local Health Officers Disease Control and Prevention Committee, it was decided that local health departments implement case-based surveillance for hospitalized varicella cases. This compromise is intended to enhance current prevention and control efforts by characterizing more severe cases which warrant hospitalization due to varicella and related complications.

Vaccination coverage has increased dramatically

in recent years. Varicella vaccine was licensed for use in March 1995. In 1996, the Advisory Committee on Immunization Practices (ACIP) recommended the routine vaccination of infants (aged 12-18 months). In 2001, one dose of varicella vaccine or physician documented disease became a requirement for entry into childcare and kindergarten. By 2002, 98% of children entering kindergarten had met this varicella school entry requirement.

Varicella vaccination critical for disease reduction

While varicella vaccination rates have improved in recent years, many still regard varicella as a childhood rite of passage or a minor illness from which children will easily recover. This perception belies its considerable morbidity and mortality. Prior to the introduction of the vaccine in 1995, approximately 4 million cases were reported annually in the U.S. including 4,000-9,000 hospitalizations and 100 deaths. Varicella vaccination is an important step to reducing these needless illnesses and deaths. Studies have shown that the varicella vaccine is 85% effective in preventing disease, and among those who do contract the disease, its symptoms are typically very mild. Following vaccination, immunity to infection can persist for more than 20 years. ¶

For more information about varicella including information about vaccination and disease reduction visit: www.cdc.gov/nip/diseases/varicella/

FATAL CASES OF VARICELLA SHOULD BE REPORTED IMMEDIATELY TO ACUTE COMMUNICABLE DISEASE CONTROL

213-240-7941 (during working hours)

213-974-1234 (after hours, emergency operator)

For questions regarding the reporting of nonfatal cases of varicella (e.g., hospitalized cases and outbreaks), contact the Immunization Program at 213-351-7800.

REPORTABLE DISEASES AND CONDITIONS**Title 17, California Code of Regulations (CCR), § 2500**

It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any diseases or conditions listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report. "Health care provider" encompasses physicians, surgeons, veterinarians, podiatrists, nurse practitioners, physician assistants, registered nurses, nurse midwives, school nurses, infection control practitioners, medical examiners, coroners, dentists and chiropractors.

Urgency Reporting Requirements:

☒ = Report immediately by telephone.

☒ = Report by mailing, telephoning or electronically transmitting a report within 1 working day of identification of the case or suspected case.

☒ = Report by telephone within 1 hour followed by a written report submitted by facsimile or electronic mail within 1 working day.

If no symbol, report within 7 calendar days from the time of identification by mail, telephone or electronic report.

REPORTABLE DISEASES

<p>Acquired Immune Deficiency Syndrome (AIDS)*</p> <p>☒ Amebiasis</p> <p>☒ Anisakiasis</p> <p>☒ Anthrax</p> <p>☒ Babesiosis</p> <p>☒ Botulism (Infant, Foodborne, Wound)</p> <p>☒ Brucellosis</p> <p>☒ Campylobacteriosis</p> <p>Chancroid*</p> <p>Chlamydial Infections*</p> <p>☒ Cholera</p> <p>☒ Ciguatera Fish Poisoning</p> <p>Coccidioidomycosis</p> <p>☒ Colorado Tick Fever</p> <p>☒ Conjunctivitis, Acute Infectious of the Newborn, Specify Etiology</p> <p>☒ Cryptosporidiosis</p> <p>Cysticercosis</p> <p>☒ Dengue</p> <p>☒ Diarrhea of the Newborn, Outbreaks</p> <p>☒ Diphtheria</p> <p>☒ Domoic Acid Poisoning (Amnesic Shellfish Poisoning)</p> <p>Echinococcosis (Hydatid Disease)</p> <p>Ehrlichiosis</p> <p>☒ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic</p> <p>☒ <i>Escherichia coli</i> O157:H7 Infection</p> <p>☒ Foodborne Disease:</p> <p>☒ (2 or more cases from separate households with same suspected source)</p> <p>Giardiasis</p> <p>Gonococcal Infections*</p> <p>☒ <i>Haemophilus influenzae</i>, Invasive Disease</p> <p>☒ Hantavirus Infections</p>	<p>☒ Hemolytic Uremic Syndrome</p> <p>Hepatitis, Viral</p> <p>☒ Hepatitis A</p> <p>Hepatitis B (Specify Acute Case or Chronic)</p> <p>Hepatitis C (Specify Acute Case or Chronic)</p> <p>Hepatitis D (Delta)</p> <p>Hepatitis, Other, Acute</p> <p>Human Immunodeficiency Virus (HIV)*</p> <p>Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)</p> <p>Legionellosis</p> <p>Leprosy (Hansen Disease)</p> <p>Leptospirosis</p> <p>☒ Listeriosis</p> <p>Lyme Disease</p> <p>☒ Lymphocytic Choriomeningitis</p> <p>☒ Malaria</p> <p>☒ Measles (Rubeola)</p> <p>☒ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic</p> <p>☒ Meningococcal Infections</p> <p>Mumps</p> <p>Non-Gonococcal Urethritis (report laboratory-confirmed chlamydial infections as chlamydia)*</p> <p>☒ Paralytic Shellfish Poisoning</p> <p>Pelvic Inflammatory Disease (PID)*</p> <p>☒ Pertussis (Whooping Cough)</p> <p>☒ Plague, Human or Animal</p> <p>☒ Poliomyelitis, Paralytic</p> <p>☒ Psittacosis</p> <p>☒ Q Fever</p> <p>☒ Rabies, Human or Animal</p> <p>☒ Relapsing Fever</p> <p>Reye Syndrome</p> <p>Rheumatic Fever, Acute</p>	<p>Rocky Mountain Spotted Fever</p> <p>Rubella (German Measles)</p> <p>Rubella Syndrome, Congenital</p> <p>☒ Salmonellosis (other than Typhoid Fever)</p> <p>☒ Scabies (Atypical or Crusted) ★</p> <p>☒ Scombroid Fish Poisoning</p> <p>☒ Shigellosis</p> <p>☒ Smallpox</p> <p>Streptococcal Infections:</p> <p>☒ Outbreaks of any Type and Individual Cases in Food Handlers and Dairy Workers Only</p> <p>☒ Invasive Group A Streptococcal Infections including Streptococcal Toxic Shock Syndrome and Necrotizing Fasciitis ★ (Do not report individual cases of pharyngitis or scarlet fever.)</p> <p>Invasive <i>Streptococcus pneumoniae</i> ★</p> <p>☒ Swimmer's Itch (Schistosomal Dermatitis)</p> <p>☒ Syphilis*</p> <p>Tetanus</p> <p>Toxic Shock Syndrome</p> <p>Toxoplasmosis</p> <p>☒ Trichinosis</p> <p>☒ Tuberculosis*</p> <p>☒ Tularemia</p> <p>☒ Typhoid Fever, Cases and Carriers</p> <p>Typhus Fever</p> <p>Varicella (hospitalized cases)</p> <p>☒ Varicella (fatal cases only)</p> <p>☒ <i>Vibrio</i> Infections</p> <p>☒ Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)</p> <p>☒ Water-associated Disease</p> <p>☒ Yellow Fever</p> <p>☒ Yersiniosis</p> <p>☒ OCCURRENCE OF ANY UNUSUAL DISEASE</p> <p>☒ OUTBREAKS OF ANY DISEASE</p>
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Notification Required of Laboratories (CCR § 2505)

<p>☒ Anthrax +■</p> <p>☒ Botulism ■</p> <p>☒ Brucellosis +■</p> <p>☒ Chlamydial infections*</p> <p>☒ Cryptosporidiosis</p> <p>☒ Diphtheria +</p> <p>☒ Encephalitis, arboviral</p> <p>☒ <i>Escherichia coli</i> O157:H7 or Shiga toxin-producing <i>E. coli</i> O157:NM +</p> <p>☒ Gonorrhea*</p> <p>☒ Hepatitis A, acute infection, by IgM antibody test or positive viral antigen test</p>	<p>☒ Hepatitis B, acute infection, by IgM anti-HBc antibody test</p> <p>☒ Hepatitis B surface antigen positivity (specify gender)</p> <p>Human Immunodeficiency Virus (HIV)*</p> <p>☒ Listeriosis +</p> <p>☒ Malaria +</p> <p>☒ Measles (Rubeola), acute infection, by IgM antibody test or positive viral antigen test</p> <p>☒ Plague, animal or human +■</p> <p>☒ Rabies, animal or human</p>	<p>☒ Salmonella +</p> <p>☒ Smallpox ■</p> <p><i>Streptococcus pneumoniae</i>, Invasive ★</p> <p>☒ Syphilis*</p> <p>☒ Tuberculosis +■</p> <p>☒ Tularemia +■</p> <p>☒ Typhoid and other <i>Salmonella</i> species +</p> <p>☒ <i>Vibrio</i> species infections +</p> <p>☒ Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses) ■</p>
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★ Reportable to the LA County Dept. of Health Services.

+ Bacterial isolates and malarial slides must be forwarded to the DHS Public Health Laboratory for confirmation. Health-care providers must still report all such cases separately.

■ Laboratories receiving specimens for the diagnosis of the diseases must immediately contact the California Dept. of Health Services; for botulism testing call 213-240-7941, for bacterial testing call 510-540-2242, for viral testing call 510-307-8575.

Non-communicable Diseases or Conditions

Alzheimer's Disease and Related Conditions	Disorders Characterized by Lapses of Consciousness	☒ Pesticide-Related Illnesses (Health and Safety Code, § 105200)
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* For questions regarding the reporting of HIV/AIDS, STDs, or TB, contact their respective programs:

HIV Epidemiology Program

213-351-8516

www.lapublichealth.org/hiv/index.htm

STD Program

213-744-3070

www.lapublichealth.org/std/index.htm

TB Control Program

213-744-6271 (for reporting) 213-744-6160 (general)

www.lapublichealth.org/tb/index.htm

To report a case or outbreak of any disease contact the Communicable Disease Reporting System Hotline
Tel: 888-397-3993 • Fax: 888-397-3778

Chronic Disease is a Leading Cause of Activity Limitation Among Non-Elderly Adults

Chronic diseases, including heart disease, cancer, stroke, and diabetes, are among the leading causes of premature death in the county and nationwide, yet little information is available on how these diseases impact quality of life and daily functioning. In addition, some chronic diseases, such as arthritis, depression, and asthma, are rarely listed as a cause of death yet are known to cause significant morbidity.

To assess the impact of selected chronic diseases on functional status among non-elderly adults (those aged 18-64 years) in the county population, the Department of Health Services analyzed data from the 1999 Los Angeles County Health Survey. This survey collected health and demographic information on a countywide random sample of 7,191 non-elderly adults. Respondents were asked if they had ever been diagnosed with heart disease, diabetes, depression, arthritis, or asthma. Respondents were also asked: "During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation." This measure, referred to as "activity limitation days" (ALDs), is part of a validated scale of health-related quality of life developed by the Centers for Disease Control and Prevention.

Overall, 25% of non-elderly adults reported having been diagnosed with at least one of the five chronic conditions, including 18% who had been diagnosed with one condition, 5% with two conditions, 1.4% with three conditions, and 0.3% with four or five conditions (Table 1). The average number of ALDs in the past 30 days increased from 1.4 days among adults not previously diagnosed with any of the chronic health conditions, to 3.9 days among those diagnosed with one condition, 6.7 days among those with two conditions, 11.1 days among those with three conditions, and 19.3 days among those with four or five conditions. The total annual number of ALDs attributable to these five conditions was 67.4 million days, accounting for 40% of

all ALDs in the county's non-elderly adult population (Table 2).


The findings indicate that chronic disease is an important cause of activity limitation among adults under 65 years of age. The results likely represent a minimum estimate of the burden of chronic disease because they do not include a number of other important chronic health conditions (e.g., cancer, HIV/AIDS, and anxiety disorders) and do not account for persons with undiagnosed disease. The five chronic conditions included in this analysis are to a large degree preventable or controllable in the non-elderly population, suggesting that there is significant opportunity to improve health-related quality of life, increase productivity, and reduce healthcare expenditures in this population. 

Table 1. Prevalence of chronic disease* and average number of activity limitation days (ALDs) in the past 30 days by the number of diagnosed conditions.

No. of diagnosed conditions	Prevalence	Average no. ALDs
0	74.9%	1.4 days
1	18.2%	3.9 days
2	5.2%	6.7 days
3	1.4%	11.1 days
4-5	0.3%	19.3 days

* Heart disease, diabetes, arthritis, depression, and asthma

Table 2. Activity limitation days (ALDs) attributable to chronic disease* in the non-elderly (aged 18-64 years) adult population.

Age group (yrs)	Annual no. of ALDs (million)	Rate of ALDs (days/person-yr)	Attributable fraction
18 - 39	18.5	5.4	24.0%
40 - 49	22.3	15.5	45.7%
50 - 64	27.5	22.7	61.6%
Total	67.4	11.1	39.5%

* Heart disease, diabetes, arthritis, depression, and asthma

PATIENT-DELIVERED PARTNER THERAPY FOR CHLAMYDIA IN LOS ANGELES COUNTY

Despite improvements in testing and treatment for urogenital chlamydia trachomatis infection (CT), the CDC estimates four million new cases in the U.S. each year. In Los Angeles County, the Sexually Transmitted Disease (STD) Program documented 32,670 cases of chlamydia in 2001, most cases (74%) were female. Women 20-24 years old had the highest rates, followed by adolescents 15-19 years old.

If left untreated, chlamydia infection among adolescent girls and women can cause pelvic inflammatory disease (PID), leading to such complications as infertility, chronic pelvic pain, and ectopic pregnancy. These sequelae are more common with re-infection. Re-infection rates in women with CT range from 13-73% and often result from failure to treat male sexual partners. Patient-delivered partner therapy (PDT) was proposed to improve treatment of partners. Patients are given extra medication to deliver to their partners, without requiring examination. Based on early PDT studies and increasing CT prevalence in California, Senate Bill 648 (Ortiz) was signed into law in September 2000. This legislation allows physicians to prescribe antibiotic therapy without examining the sex partners of persons with laboratory-

confirmed CT infections.

In order to help clarify some of these issues surrounding PDT implementation, the STD Program is conducting a year-long study that will evaluate the acceptance of PDT from both a provider and patient perspective. The STD Program proposes to enroll women testing positive for CT from two county clinic sites and four community college clinics. Women diagnosed with CT will be offered PDT versus standard partner elicitation, referral, and counseling.

One of the main objectives of the study will be to determine the acceptance rate of PDT in the different clinic populations and by different demographic and risk variables identified through a series of patient, partner and provider surveys. Assessments will include: attitudes about PDT, perceived barriers to successful implementation, numbers of identified partners who complete therapy and demographic and risk variables of patients and partners who successfully receive PDT. The study will also conduct three-month follow-up testing of patients to assess CT re-infection rates in both the PDT acceptance and PDT refusal groups. ☞



ANTIBIOTIC RESISTANCE INFORMATION CORNER

Effectiveness of an Educational Intervention in Modifying Parental Attitudes About Antibiotic Usage in Children

Taylor JA, Kwan-Gett TC, and McMahon EM

Pediatrics 2003; 111(5):e548-e554.

Available at: www.pediatrics.org/cgi/content/full/111/5/e548

This article presents support for interventions to educate parents of young children about appropriate use of antibiotics. Participating pediatric offices provided parents both a pamphlet and videotape about appropriate antibiotic use (intervention group) or brochures about effective injury prevention (control group). Responses between groups showed significant attitudinal changes that would promote appropriate antibiotic use. Intervention group parents were statistically less likely than control group parents to agree that: 1) antibiotics are necessary when a child's nasal discharge is green in color, 2) it is worth trying an antibiotic in their children when upper respiratory illness (URI) symptoms persist for 5 days, 3) antibiotics are useful in treating a cold, 4) giving antibiotics to a child with a URI can prevent a bacterial infection, and, 5) antibiotics help URI symptoms clear up more quickly. The authors suggest that reducing parents' expectations of the utility of antibiotics may subsequently reduce their demands for unnecessary antibiotic for their children. Results of this study highlight the importance of how patient educational materials supplemented by the clinician's explanation of the information can change parent attitudes about antibiotics use for specific childhood conditions.

Patient education materials and other resources are available online at

The Centers for Disease Control and Prevention: www.cdc.gov/drugresistance/community/

Acute Communicable Disease Control Program: www.lapublichealth.org/acd/antibio.htm ☞

Calendar

Eliminating Health Disparities

This important course offers insights into working with diverse communities and brings you the latest in immunization outreach strategies.

To register, contact Ina Hasley at inhasley@dhs.co.la.ca.us or at 213-351-7800 and provide the following information: name, address, organization, phone #, fax #, and email address.

Date: Thursday, July 10, 2003
Time: 9:00 a.m. – 11:00 a.m.
Place: Health Services Administration - Auditorium
313 North Figueroa Street
Los Angeles, CA 90012

Reminder: Pediatric MRSA now reportable in LA

In response to the notable increase in community-associated methicillin-resistant Staphylococcus aureus (CAMRSA) occurring in Los Angeles County, for the period of May to November 2003, the Department of Health (LACDHS) has added skin, soft tissue and invasive MRSA infections to the list of local reportable diseases. This new reporting requirement will be limited to infections among hospitalized children (<18 years) and excluding those with nosocomial (healthcare associated) infections, unless as part of an outbreak. Submissions of the MRSA isolate and antibiogram are also required.

Questions and additional information can be addressed by calling Acute Communicable Disease Control (213-240-7941) during working hours or by visiting www.lapublichealth.org/acd/MRSA.htm.

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THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County



COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health

313 North Figueroa Street, Room 212
Los Angeles, California 90012

Selected Reportable Diseases (Cases)¹ - February 2003

Disease	THIS PERIOD Feb 2003	SAME PERIOD LAST YEAR Feb 2002	YEAR TO DATE		YEAR END TOTALS		
			2003	2002	2002	2001	2000
AIDS ²	242	155	349	266	1,787	1,354	1,648
Amebiasis	7	7	19	13	109	139	109
Campylobacteriosis	80	60	177	153	1,092	1,141	1,273
Chlamydial Infections	3,102	2,507	5,271	4,492	36,590	31,658	30,642
Encephalitis	5	3	8	9	63	41	49
Gonorrhea	584	575	1,017	1,073	7,985	7,468	7,212
Hepatitis Type A	30	47	64	87	482	542	839
Hepatitis Type B, Acute	4	3	7	5	27	44	65
Hepatitis Type C, Acute	2	0	2	1	3	1	28
Measles	0	0	0	0	0	8	5
Meningitis, viral/aseptic	26	37	67	90	669	530	491
Meningococcal Infections	4	12	8	14	46	58	53
Mumps	1	0	2	1	16	17	29
Non-gonococcal Urethritis (NGU)	115	122	156	174	1,398	1,343	1,575
Pertussis	21	6	25	24	167	103	102
Rubella	0	0	0	0	0	0	3
Salmonellosis	54	76	146	180	990	1,006	990
Shigellosis	90	57	195	125	922	684	849
Syphilis, primary & secondary	26	13	58	31	362	181	136
Syphilis, early latent (<1 yr.)	21	21	49	42	341	191	194
Tuberculosis	53	48	68	65	1,025	1,046	1,065
Typhoid fever, Acute	0	1	1	2	34	17	21

1. Case totals are provisional and are subject to change following publication.

2. Case totals are interim and may vary following periodic updates of the database.